Eliminating Tobacco-Related Disease and Death: Addressing Disparities—A Report of the Surgeon General

Key Findings

The 2024 Surgeon General's Report Overview

Eliminating Tobacco-Related Disease and Death: Addressing Disparities—A Report of the Surgeon General is the 35th tobacco-related Surgeon General's Report published since 1964. In 1998, the Surgeon General issued the report, *Tobacco Use Among U.S. Racial/Ethnic Minority Groups*, which was the first report to exclusively examine racial and ethnic disparities in tobacco use. The 2024 report documents the persistence of disparities in tobacco product use and exposure to secondhand tobacco smoke and acknowledges poverty and discrimination as key drivers of disparities. The scientific evidence in this report supports the following key findings.

2024 Surgeon General's Report Findings

1. Despite strong progress in reducing tobacco use at the population level, disparities in use persist by race and ethnicity, level of income, level of education, sexual orientation, gender identity, type of occupation, geography, and behavioral health status. Exposure to secondhand tobacco smoke remains disproportionately higher among Black people than among people in other racial and ethnic groups, youth than among adults, and people from lower socioeconomic backgrounds than among those from higher socioeconomic backgrounds.
2. Tobacco-related health disparities are a social injustice, in addition to an economic and health burden. Addressing disparities requires reflection on the complex history of the commercialization of tobacco and both past and present-day experiences of racism, discrimination, and targeted marketing by the tobacco industry.
3. Social, structural, and commercial determinants of health—such as persistent poverty and inequitable economic and social conditions—lead to inequitable opportunities for living a life free from tobacco-related death and disease. Racism, discrimination, and targeted marketing by the tobacco industry; geographic disparities in evidence-based policy protections; preemptive laws that thwart communities from protecting their residents' health and safety; and financial and other structural barriers to accessing cessation treatments also drive tobacco-related health disparities.
4. The tobacco industry has designed, engineered, and marketed menthol cigarettes and other tobacco products that deliver multisensory flavor experiences which increase the likelihood of tobacco initiation, addiction, and sustained use. Policies that restrict the availability of menthol cigarettes can reduce smoking initiation and prevalence among adolescents, young adults, Black people, and other population groups that have disproportionately higher use of menthol cigarettes.

5. For decades, the tobacco industry has targeted its products and marketing to specific groups, including through concentrated marketing in neighborhoods with greater percentages of Black people, Hispanic people, and residents with lower incomes. Tobacco companies employ multiple tactics to undermine tobacco prevention and control efforts and enhance their corporate image.

6. Cigarette smoking remains a major cause of death and disease — including cancer, cardiovascular disease, and chronic obstructive pulmonary disease (COPD) — among all racial and ethnic groups. More than 490,000 deaths attributable to cigarette smoking and exposure to secondhand tobacco smoke are estimated to occur in the United States each year — about one in five of all deaths in the United States. This includes more than 473,000 deaths attributable to cigarette smoking and more than 19,000 deaths attributable to exposure to secondhand tobacco smoke.

7. Each year, more than 50,000 Black adults, 15,000 Hispanic adults, and 400,000 White adults are estimated to die from causes attributable to cigarette smoking. Despite large absolute differences in the numbers of smoking-attributable deaths by race and ethnicity, smoking accounts for a similar proportion of deaths among non-Hispanic Black (18%) and non-Hispanic White (20%) people and about 10% of deaths among Hispanic people.

8. Data from surveillance and intervention research are limited for many groups known to be at high risk for tobacco use, exposure to secondhand tobacco smoke, and targeted marketing by the tobacco industry. While protecting recent gains in measurement, further efforts are warranted to assess structural and social determinants of health across the lifespan, disaggregate data, oversample disparate populations, and increase understanding of the impact of interventions on tobacco-related health disparities.

9. Endgame efforts to eliminate tobacco-related disease, disability, and death should create opportunities and conditions for all people to live healthy lives that are free from commercial tobacco. Interventions designed to reduce the use of tobacco products and the influences of the tobacco industry on society should accompany efforts to remove the underlying social, structural, commercial, and political drivers of health inequities.

10. In addition to social and structural interventions, a comprehensive and multilevel effort toward health equity must include a combination of complementary approaches to reduce the affordability, accessibility, appeal, and addictiveness of tobacco products; eliminate exposure to secondhand tobacco smoke; conduct high-impact media campaigns; and promote barrier-free access to cessation support with broad reach to disparate populations. Strategies should be implemented equitably and with fidelity in all jurisdictions.